

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-001005

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 111

Primary Registration District No. 4183

Registrar's No. 121

FILED JAN 30 1963

1. PLACE OF DEATH

a. COUNTY

FRANKLIN

b. CITY (If outside corporate limits, give TOWNSHIP only)
OR
TOWN

PACIFIC

Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

b. COUNTY

admission)

c. CITY
OR
TOWN

PACIFIC

Inside Limits

Yes ☐ No ☒c. FULL NAME OF (If NOT in hospital, give location)
HOSPITAL OR
INSTITUTION

R.R. # 2

Inside Limits

Yes ☐ No ☐d. STREET
ADDRESS (If outside, give location)

R.R. # 2

Reside on Farm

Yes ☒ No ☐3. NAME OF DECEASED
(Type or print)First
RICHARDMiddle
LEELast
GARLICK4. DATE
OF
DEATHMonth
JAN.Day
26Year
19635. SEX
MALE6. COLOR OR RACE
WHITE7. Married ☐ Never Married ☒
Widowed ☐ Divorced ☐

8. DATE OF BIRTH

9. AGE (last birthday)

IF UNDER 1 YEAR

IF UNDER 24 HR

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

STUDENT

10b. KIND OF BUSINESS OR INDUSTRY

HIGH SCHOOL

11. BIRTHPLACE (City and state or country)

CHILLICOTHE, MO.

12. CITIZEN OF WHAT COUNTRY

U.S.A.

13a. FATHER'S NAME

RAYMOND A. GARLICK

13b. MOTHER'S MAIDEN NAME

AMANDA SPROUSE

14. NAME OF HUSBAND OR WIFE

NONE

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give war or date)

NO

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

MRS. AMANDA GARLICK R.R. #2 PACIFIC

18. CAUSE OF DEATH (Enter only one cause
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Conditions, if any,
which gave rise to
above cause (a),
stating the under-
lying cause last.

DUE TO (b)

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal
disease condition given in PART I. (a)PART III. If deceased was female was
there a pregnancy in last 90 days.☐ Yes ☐ No ☐ Unknown19. WAS AUTOPSY
PERFORMED?
YES ☐ NO ☒20a. ACCIDENT ☐ SUICIDE ☒ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF
INJURYHour
2:00
p.m.Month, Day, Year
1/26/6320d. INJURY OCCURRED
WHILE AT WORK ☐
NOT WHILE AT WORK ☒20e. PLACE OF INJURY (e.g., in or about home,
farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from
Death occurred at

2:00 p.m.

to
on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

22b. ADDRESS

22c. DATE SIGNED

23a. BURIAL, CREMATION,
REMOVAL (Specify)

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City, town, or county)

(State)

REMOVAL

JAN. 29, 1963

RESTHAVEN MEM. GAR.

CHILLICOTHE

MO.

24. FUNERAL DIRECTOR

ADDRESS

25. DATE RECD. BY LOCAL REG.

26. REGISTRAR'S SIGNATURE

THIEBES FUNERAL HOME PACIFIC, MO.

Jan. 29-63 Mary B. Gross.

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

INSTEAD OF

DATE AMENDED

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

VS 300
Rev. 4/59

1 2360

2 2360

3

4 0

5 0

6

7 0

8 2

9 974X

10

11

12 91-3

13 1-0

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Ralph Altman

Licensed Embalmer No. 4808

P. O. Address Union, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.